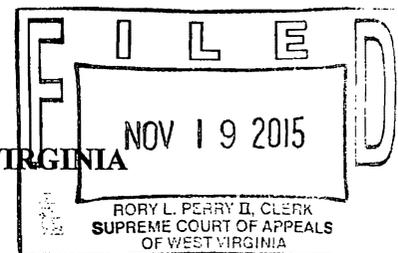


IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

DOCKET NO. 15-0595



HEARTLAND OF BECKLEY WV, LLC
HEARTLAND OF CLARKSBURG WV, LLC
HEARTLAND OF MARTINSBURG WV, LLC
HEARTLAND OF RAINELLE WV, LLC
HEARTLAND-PRESTON COUNTY OF KINGWOOD, LLC
HEALTH CARE and RETIREMENT CORPORATION OF AMERICA, LLC
d/b/a HEARTLAND OF CHARLESTON,

Petitioners,

v.

BUREAU FOR MEDICAL SERVICES,

Respondent.

REPLY BRIEF OF PETITIONERS

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I. INTRODUCTION

Petitioners Heartland of Beckley WV, LLC, Heartland of Clarksburg, WV, LLC, Heartland of Keyser WV, LLC, Heartland of Martinsburg, WV, LLC, Heartland of Rainelle, WV, LLC, Heartland-Preston County of Kingwood WV, LLC, and Health Care and Retirement Corporation of America, LLC, d/b/a Heartland of Charleston (collectively, “HCR”) submit this reply in support of their appeal and in reply to the brief of Respondent Bureau for Medical Services (the “Bureau” or “BMS”).

After more than 18 months of dispute as to the legal rules governing, and the allowability of, settlement and other “first dollar” costs (liability costs paid below an insurance deductible), the response brief (“Response”) of BMS asserts that those issues are irrelevant. The Response begins by stating that “the relevant issue in this case . . . [is] the reasonableness of the rates” HCR sought from the Bureau. BMS Br. at 3. The BMS brief makes clear, in strident tones accompanied by inaccurate claims, that the concern of the Bureau is simply a belief that the costs submitted would lead to unreasonably high rates, accompanied by the suspicion that the costs are HCR’s fault.

BMS does not and cannot cite any evidence in the record that HCR could have obtained lower insurance rates or deductibles. BMS does not assert that there was evidence that HCR’s settlement payments were unwise or that its legal costs were imprudently incurred. It cites no evidence that other national chains were able to provide liability protection at lower rates. BMS simply asks the Court to accept an irrebuttable presumption that any costs significantly higher than the average for other reporting West Virginia facilities are “unreasonable.”

Operation of the existing CAP methodology created by BMS would have excluded all HCR costs above the 90th percentile for each bed group. As BMS concedes, the purpose of the

CAP was to limit costs. Because the outcome of applying the CAP methodology results in a number too high for its comfort, BMS asserts that that a *type* of expense can be excluded in order to insure that the *outcome* is in a range BMS approves. Prior to excluding the particular type of expense, BMS undertook no steps to ascertain a reasonable level of expense by any process of investigation, review of evidence, survey of insurance costs for providers like HCR, or even simple discussion. The actual approach of BMS actually allowed several facilities to include higher liability costs than HCR was allowed to include.

Because of the assertion by BMS below (now allegedly abandoned) that a legal rule precluded the type of expense at issue, the hearing focused on that Bureau claim and on the Bureau's prior reversals in position. HCR did introduce evidence of reasonableness, particularly as to its limited insurance options and the reasons it faced higher liability costs than typical providers. The BMS brief pretends that the evidence did not exist. BMS, in fact, does little more than request that this Court assume that HCR's costs must result from improper care, and that any costs over historical averages are "unreasonable." The increased costs are certainly a reasonable basis to inquire as to the justification for the increases and to assess reasonableness. BMS undertook no such process, and actively hindered HCR in understanding its concerns.

Having initially relied on the Provider Reimbursement Manual ("PRM"), BMS now abandons it, with the claim that it is relevant only to self-insured providers. The 30 chapters of the PRM deal with many other subjects. The plain language § 2162.5 expressly allows for inclusion of expenses paid below an insurance deductible ("losses relating to the deductible are allowable costs in the year paid . . .").

The Bureau's interpretation of the State Plan, which has changed several times, is not entitled to deference. In any event, the Bureau concedes that federal law is ultimately controlling

through the preemption doctrine. Any state law and policy must be consistent with federal law as the Bureau has recognized in its brief as well as the Provider Manual § 514.23.¹ The Bureau cannot claim what is expressly permitted by federal law is precluded by state restrictions.

The inconsistencies in its brief suggest that BMS may still argue some rule of law categorically precludes expenses other than insurance premiums. If so, that position, like the initial decision of BMS, further violates due process and rulemaking procedures. That would amount to changing the method of setting Medicaid reimbursement rates and the CAP without notice and an opportunity to be heard.

The failure of BMS to disclose the true basis for its actions would entitle HCR to a full hearing on the actual relevant standard, if the Court concludes that the “reasonableness” of the costs is the governing standard, and that BMS has preserved its rights on the point. To the extent the Court should conclude that other rules of law govern that would allow exclusion of costs based on the *type* of cost, HCR would be entitled to discovery. The Bureau concedes that discovery is available on certiorari and does not dispute that discovery procedures do not exist at the administrative level. Its suggestion that HCR’s request for discovery was untimely is specious because it was made promptly following the hearing at which the circuit court identified issues upon which the request for discovery was made. Moreover, the Bureau’s argument that it does not have relevant information is disingenuous. Finally, the Bureau does not really dispute that the circuit court should have reviewed the entire administrative record, including evidence stricken, proffers made, and supplementations. The Bureau hampered the circuit court’s *de novo* review of the administrative proceedings by submitting only the transcript of the administrative hearing. Therefore, this Court should reverse the circuit court’s order and remand this action and

¹ See <http://www.dhhr.wv.gov/bms3/Documents/Manuals%20Archive/Chap514NursingFacility2011.pdf>.

direct allowance of the excluded costs. Alternatively, the Court should remand for further proceedings to assess reasonableness and/or explore the Bureau's change in policy and its prior knowledge of longstanding practice.

II. DISCUSSION

A. The Circuit Court Erred in Denying HCR's Petition for Appeal.

1. The Bureau's brief changes the agency's position again, and fails to show that the costs disallowed were unreasonably high.

The Bureau repeatedly asserts in its brief that the "reasonableness" of the costs reported by HCR for its liability expenses is "the relevant issue." *See, e.g.* BMS Br. at 3, 13. The brief is also rife with insinuations that the costs must have been the fault of HCR or that they arise from bad practices of HCR, rather than its position as an attractive target based on its national size. Had the Bureau based its two prior decisions based on those concerns, the parties could have fully developed them. As it was, the Bureau's initial decision denied inclusion of the costs and the reimbursement formula based on the explicit position that Section 2162.7 of the Provider Reimbursement Manual governed the issue, and that HCR did not meet the requirements of a "self-insurance trust" set forth in that section of the PRM. A.R. at 769. Consequently, BMS continued with an exclusion of the *category* of liability costs that relate to settlement and direct payment of all items other than insurance premiums. It was that desk review decision that guided HCR in the hearing.

BMS now claims that the amounts excluded were excluded simply because they were too high, not because of the type of cost they were. Yet there was no finding, in the initial disallowance notice, in the desk review decision, or even in the decision of the hearing examiner, as to what portion of the settlement costs caused the allowable costs from HCR to cross from "reasonable" to "unreasonable." A.R. at 469, 791-800, 15-39. The BMS arguments to this Court

and the court below cannot cure this defect because “*post hoc* rationalizations” of an agency’s counsel cannot validate an agency decision, which must be “upheld, if at all, on the same basis articulated in the order by the agency itself.” *Webb v. W. Va. Bd. of Med.*, 212 W. Va. 149, 158, 569 S.E.2d 225, 234 (2002).

The total silence of the agency decisions below also does not allow an assumption that the first dollar of settlement costs spent by each facility was, by miraculous coincidence, the tipping point at which costs moved from “reasonable” to “unreasonable.” Aside from the legal invalidity of such an assumption, the Bureau’s brief inadvertently points out that the removal of all costs other than insurance premiums caused several HCR facilities to fall below the Bureau’s re-calculated CAP. The Bureau’s brief notes that the HCR facilities fell from occupying the top six (most expensive) positions in reported expense, to occupying positions 36 through 49. BMS Br. at 8. As the Bureau’s own exhibit shows, after the arbitrary exclusion based on the type of cost (direct liability costs, rather than insurance premiums), the Bureau’s recalculation allowed inclusion of costs at seven facilities that were higher than some HCR facilities. AR at 438.²

Finally, the argument that there was a reasoned assessment of the proper level of “reasonable costs” is refuted by the Bureau’s brief, which concedes that it excluded reported costs that were of a certain type — “paid settlement claims”—rather than costs over a calculated limit. BMS Br. at 6. The Bureau’s decision below did not contain an assessment of reasonable costs, an analysis of expert evidence, consideration of similar facilities, evidence of available coverage and their costs, or a calculation or explanation of a conclusion as to the “reasonable cost” limit. The Bureau did not consider the uncontested testimony of HCR’s witnesses that HCR’s liability protection arrangements were the lowest cost available, and that the higher costs

² The Bureau’s recalculated CAP would disallow amounts above \$25.27, and position 46 in the rankings. Seven non-HCR facilities were above position 36, the position assigned to Heartland of Charleston under the Bureau’s approach.

of HCR compared to most West Virginia facilities is a result of its position as a national chain and its “target” status. A.R. at 191-93. The Bureau simply asks this Court to assume that the increased costs are unreasonable, without assessment of anything but a comparison between the HCR facilities and West Virginia averages.

The Bureau did not (and does not) explain which portion of the direct liability costs moved a facility over the line of “reasonableness” or where that line was. No portion of the direct liability costs (such as settlements) was included for any facility, each of which was cut off at different points. A.R. at 438. Thus, there was no reasoned determination below of a generic “reasonableness” limit that would justify disregarding the Bureau’s own existing CAP methodology, and re-writing it to achieve a more “acceptable” result.

Having denied HCR below a statement of the actual basis (now revealed) for the Bureau action, the Bureau should not now be heard to request an opportunity to support its assumption as to the costs at issue. However, HCR recognizes that there is some right to assess reasonableness of costs, even when the Bureau’s own cost CAP methodology would authorize inclusion of the costs. If this Court is persuaded that BMS should conduct a hearing on the reasonableness question, it should remand the case for development of the evidence on that question. Any such remand should clarify that the prior BMS claims that payments below an insurance deductible are categorically barred is an error of law. Federal law clearly authorizes such costs, as shown below.

2. HCR met the requirements of the Medicaid Act, its corresponding regulations, and the PRM § 2162.5.

HCR met the requirements of 42 U.S.C. § 1396a(a)(30)(A), and its corresponding regulation 42 C.F.R. § 447.253(b)(1). The Bureau concedes on page 13 of its brief that federal law on Medicaid reimbursement is controlling. In fact, both parties cite to 42 C.F.R. § 447.253(b)(1), which requires “rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal Laws, regulations, and quality and safety standards.”³ The Bureau, however, ignores the PRM § 2162.5, which specifically discusses the allowability of actual losses related to deductibles, and provides in part:

Where you, at your option, are willing to commit your resources toward meeting first dollar losses through a deductible (as defined below), losses relating to the deductible are allowable costs in the year paid without funding if the aggregate deductible is no more than the greater of 10 percent of your (or, if appropriate, a chain organization’s) net worth – fund balances as defined for Medicare cost reporting purposes – at the beginning of the insurance period or \$100,000 per provider

A.R. at 785.

The Bureau’s sole basis for disregarding the PRM is that because HCR is not self-insured it is not “necessary to utilize the PRM for guidance regarding self-insured providers.” BMS Br. at 20. That does not explain why the rest of the PRM is to be ignored, given that most of its 30 chapters do not deal with a “self-insured provider.” The Bureau’s Provider Manual, to which the Bureau does not refer in its brief, acknowledges the authority of federal regulations and cost principles when Medicaid regulations are silent. Provider Manual § 514.23.

³ HCR also relies on 42 U.S.C. § 1396a(a)(30)(A), which is the statutory counterpart to Section 447.253(b)(1). Oddly, the Bureau argues in footnote 4 of its brief that HCR’s reliance on Section 1396a(a)(30)(A) is inappropriate because that section does not provide a private right of action or a right enforceable under 42 U.S.C. § 1983. The Bureau’s argument is specious because this appeal does not involve an action under Section 1983. The Bureau cannot maintain that Section 1396a(a)(30)(A) does not provide the controlling standard of law.

Not surprisingly, numerous courts have recognized the authority of the PRM in Medicaid payment disputes. BMS makes no effort to distinguish the cases previously cited, recognizing that PRM §2162.5 governs recovery of first dollar losses as permissible costs.⁴ Numerous other cases recognize the PRM in resolving Medicaid reimbursement issues. *See, e.g., Beverly Health & Rehabilitation Services, Inc. v. Metcalf*, 24 Va. App. 584, 594-95, 484 S.E.2d 156 (1997) (holding that the state administrative agency is required to apply Medicare principles of reimbursement, including those stated in the PRM when the State Plan is silent on a particular issue); *Dep't of Health & Mental Hygiene v. Riverview Nursing Ctr., Inc.*, 104 Md. App. 593, 598 657 A.2d 372, 374 (1995) (noting that, when the state's federally-approved Medicaid reimbursement plan does not specify otherwise, "federal Medicare principles of reimbursement, contained in the Medicaid Act, Provider Reimbursement Manual (PRM), and Medicare regulations control"); *In re McKerley Health Facilities*, 145 N.H. 164, 167, 761 A.2d 413, 415 (2000) (relying on PRM to resolve Medicaid reimbursement issue not addressed in state regulations); *Hampton Nursing Ctr. v. State Health & Human Servs. Fin. Comm'n*, 303 S.C. 143, 399 S.E.2d 434 (Ct. App. 1990) (looking to the Provider Reimbursement Manual guidelines, which were incorporated into contracts governing Medicaid contracts, in assessing reimbursement of interest related to Medicaid services provided by a nursing home).

In this action, the Bureau concedes on page 20 of its brief that it argued below that HCR was not self-insured within the meaning of the PRM § 2162.7. The Bureau cannot cherry pick the PRM. When HCR pointed out that it was not self-insured and that the applicable provision

⁴ The cases, cited on page 18 of HCR's brief, are *American Healthcare, LLC v. Department of Medical Assistance Services*, No. CL11000548-00, 2012 WL 7964273 (Va. Cir. Ct. Jan. 12, 2012), or *Oroville Hospital v. Department of Health Services*, 146 Cal. App. 4th 468, 52 Cal. Rptr. 3d 695 (2007). Both of these cases specifically held that first dollar losses or liability costs up to deductible amounts were allowable costs under the PRM § 2162.5.

of the PRM was § 2162.5, which expressly permits first dollar losses relating to a deductible, the Bureau suddenly asserted that the PRM did not apply.

Under the PRM, HCR's first dollar losses and liability costs were not only allowable but presumptively reasonable up to its deductible under PRM § 2162.5. The Bureau does not dispute that the provisions of §2162.5 are met and has been at pains to trade on HCR's size. The Bureau supplemented the administrative record with a brief from *Manor Care, Inc. v. Douglas*, 234 W. Va. 57, 763 S.E.2d 73 (2014), that characterizes HCR as a billion dollar conglomerate⁵ and inserted references to this Court's decision in *Manor Care, Inc.* that HCR has nearly \$8 billion in assets. *Id.*, 763 S.E.2d at 101.

In addition, there was no evidence of any kind that HCR had been unreasonable or imprudent in structuring its insurance program. The Bureau submitted not a single word of testimony, and not a single exhibit of any kind, on the point. HCR explained that it was insured for all losses over \$10,000,000 by various policies and reinsurance agreements. A.R. at 186. HCR further explained in detail its insurance program, the layers of coverage, and its ongoing efforts to ensure that it had left undetected no superior alternative. A.R. at 186-89. Indeed, on cross-examination HCR explained that “[o]n advice from our insurance brokers we were told that that was the program of insurance that they recommended and we agreed as being the most economical.” A.R. at 202. The Bureau never suggested that HCR was unreasonable in its choices. Moreover, the Bureau did not suggest at any time (much less provide evidence) that any other structure was even available. In fact, the sole testimony at the hearing was that HCR did not have the option, at the relevant time, for lower liability limits. A.R. at 187-88.

The Bureau's argument beginning on page 13 of its brief is fundamentally flawed because it ignores the PRM and simply assumes that having higher costs than average West

⁵ This brief and several other documents, however, were omitted from the circuit court's record by the Bureau.

Virginia providers shows a lack of reasonableness. The Bureau also does not make relevant comparisons. Instead of comparing HCR's first dollar losses and liability costs up to its deductible of \$10,000,000 to its net worth of \$4 billion as directed under the PRM § 2162.5, the Bureau compares HCR's insurance costs to those of other unidentified and undoubtedly smaller and otherwise dissimilar facilities, and it compares the CAP with and without inclusion of first dollar losses and liability costs up to deductibles in allowable costs. The Bureau cites no authority to support the validity of these comparisons. Manifestly, the Bureau's comparisons are not valid under the PRM § 2162.5 or any other standard. They are no basis to disallow HCR's first dollar losses and liability costs up to its deductible in this action.

3. BMS's interpretation of the State Plan, which has changed several times, is not entitled to deference and is preempted by federal law in any event.

The Bureau's interpretation of the State Plan, which has changed several times, is not entitled to deference. The Bureau admits on page 17 of its brief that Medicaid reimbursement rates are preempted by federal law. *Appalachian Reg'l Healthcare, Inc. v. W. Va. Dep't of Health & Human Res.*, 232 W. Va. 388, 752 S.E.2d 419, 428 (2013). Next, the Bureau again cites to 42 C.F.R. § 447.253(b)(1)(i) as controlling authority. Of course, Section 447.253(b)(1)(i) is a federal regulation, not a Bureau regulation. The Bureau is not entitled to deference when interpreting a federal regulation as opposed to one of its own regulations.

Nor is the Bureau entitled to deference with interpreting the State Plan because its interpretation has changed over time and is inconsistent with federal law. The portion of the State Plan relevant to this appeal provides:

Allowable Costs for Cost Centers

Cost Center areas are standard services, *mandated services*, nursing services, and capital. A cost upper limit is developed for each cost center area and becomes the

maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

...

Mandated Services

Mandated services are defined as Maintenance, Utilities, *Taxes and Insurance* and Activities. Reported allowable cost for these services is fully recognized to the extent that it does not exceed the percentile of allowable reported costs by facility classification as determined by the current cost reports.

A.R. at 410-11 (emphasis added).

The Bureau’s interpretation of the State Plan § 4.19, which has changed several times, is inconsistent with federal law. Although the plain language of the State Plan § 4.19 is not problematic on its face, the Bureau does not dispute that in its interpretation of the term “allowable costs” it ignores the question of reasonableness from the proper perspective of an efficiently and economically operated provider under § 447.253(b)(1)(i). Nor does the Bureau dispute that its position in this case is a dramatic departure from the past, or that its justification for the position changed repeatedly at every stage of the proceedings. In three levels of review, the Bureau and the circuit court articulated at least three different erroneous justifications for the cost-cutting measures taken by Office of Accountability & Management Reporting (“OAMR”). This does not reflect a longstanding interpretation of its own rules entitled to deference under *Crocket v. Andrews*, 153 W. Va. 714, 172 S.E.2d 384, Syl. Pt. 3 (1970) (holding that “[w]hile long standing interpretation of its own rules by an administrative body is ordinarily afforded much weight, such interpretation is impermissible where the language is clear and unambiguous”).

The Bureau’s reliance on *Wishing Well Health Center. v. Bureau for Medical Services*, Civil Action No. 04-AA-85 (Kanawha Cty., W. Va. Apr. 1, 2005), on page 19 of its brief is

misplaced. *Wishing Well Health Center* did not involve allowable costs or any other issue relevant here, but only the required documentation for certain salary costs, and it does not stand for the broad proposition argued by the Bureau. A.R. at 953-56. Moreover, two years later, the circuit court reached the opposite conclusion, finding that the Bureau acted arbitrarily and capriciously when it reinterpreted the meaning of the term “operator” because it was convenient for the Bureau in a particular instance. See *Maples Health Care, Inc. v. Bureau for Med. Servs.*, Civil Action No. 05-AA-182 (Kanawha Cty., W. Va. Apr. 6, 2007). That is exactly what the Bureau has attempted to do in this action. Accordingly, the Bureau’s interpretation of the State Plan is not entitled to deference.

4. **BMS violated due process and rulemaking procedures by arbitrarily and capriciously disallowing HCR’s losses relating to deductibles and changing its method of setting Medicaid reimbursement rates and the CAP without notice and comment.**

BMS also violated due process and rulemaking procedures by arbitrarily and capriciously disallowing HCR’s losses relating to deductibles and changing its method of setting Medicaid reimbursement rates and the CAP without notice and comment. The Bureau does not dispute that the Medicaid Act requires, among other things, that a State Plan include both procedural and substantive elements for setting rates and provides: “(A) for a public process for determination of rate of payment under the plan for . . . nursing facility services . . . under which (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published, (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications, [and] (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published[.]” 42 U.S.C. § 1396a(a)(13)(A). Nor does the Bureau dispute that 42 C.F.R. § 447.205 requires

public notice of any significant proposed change in the methods and standards for setting payment rates for Medicaid services.

The parties are in agreement that the Bureau did not change a *published* regulation or rule applicable to this appeal. Contrary to the Bureau's argument beginning on page 15 of its brief, its change in the approach to first dollar losses and liability costs up to a deductible is just the type of change in administrative policy that should be accompanied by appropriate notice and comment. Nonetheless, the Bureau did not provide the notice and comment required under 42 U.S.C. § 1396a(a)(13)(A) and 42 C.F.R. § 447.205.

Moreover, the Bureau does not attempt to distinguish *C & P Telephone Co. of West Virginia v. Public Service Commission of West Virginia*, 171 W. Va. 708, 301 S.E.2d 798, 804 (1983), *Coordinating Council for Independent Living, Inc. v. Palmer*, 209 W. Va. 274, 546 S.E.2d 454 (2001), or *Weirton Heights Volunteer Fire Department, Inc. v. State Fire Commission*, 218 W. Va. 668, 628 S.E.2d 98 (2005), which are discussed in HCR's brief on page 25. These cases collectively hold that an agency must give appropriate notice of a change in its position and reasons for the change.⁶

The Bureau's argument on page 17 of its brief that if HCR's position is adopted the West Virginia Medicaid program would be required to pay whatever costs and rates the providers choose is specious. HCR agrees that 42 C.F.R. § 447.253(b)(1) requires "rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal Laws,

⁶ BMS improperly disregards the rules of law laid down by this Court, and instead attempts again to rely on on *Wishing Well Health Center v. Bureau for Medical Services*, Civil Action No. 04-AA-85 (Kanawha Cnty., W. Va. Apr. 1, 2005). That circuit court decision does not alter this Court's precedent. Moreover, as noted above, the same circuit court found that the Bureau acted arbitrarily and capriciously when it reinterpreted the meaning of the term "operator" because it was convenient for the Bureau in a particular instance. See *Maples Health Care, Inc. v. Bureau for Med. Servs.*, Civil Action No. 05-AA-182 (Kanawha Cnty., W. Va. Apr. 6, 2007).

regulations, and quality and safety standards.” The allowability of actual losses related to deductibles, however, is further addressed in the PRM § 2162.5, which establishes a specific standard of presumptive reasonableness, and the Bureau’s CAP is designed to ensure reasonableness and limit costs. If in a particular case other principles of reasonableness are not met, BMS must make a specific showing and not rely on *ipse dixit* or mere appearances, with no investigation or assessment.

Reasonableness of expenses is not a decision to be made at the personal discretion of BMS employees, with no notice, assessment or discussion. Prevention of such arbitrary action is the very purpose of notice and comment requirements. To the extent that the Bureau believes its own methodology is not sufficient to ensure reasonable rates, it has a duty to properly promulgate new rules—not to arbitrarily exclude whatever expenses it deems necessary to reach a figure it finds “reasonable,” apparently at the discretion of Jeanne Snow.

5. West Virginia public policy does not prohibit BMS from reimbursing HCR for losses relating to deductibles.

The circuit court erroneously concluded that West Virginia public policy prohibits the Bureau from reimbursing HCR for losses relating to deductibles. The Bureau failed to provide any meaningful response whatsoever to HCR’s extensive analysis of public policy in favor of allowability of costs relating to deductibles. The Bureau’s only attempt at addressing public policy is to refer to 42 C.F.R. § 447.253(b)(1) and then conclude without any further analysis in footnote 6 of its brief that “[t]herefore, clearly, West Virginia public policy does prohibit BMS from reimbursing HCR for losses relating to deductibles.” That conclusion is incorrect, because federal law expressly approves payment of “first dollar deductible” costs. PRM § 2162.5. BMS does not contend that the provisions of § 2162.5 are not met, but simply argues that it does not

apply. That is wrong, and does not change the “public policy” expressly endorsed by federal law.

Finally, the newly-discovered theory of the circuit court, not adopted by the Bureau, is an invalid basis for affirming the decision. *Webb v. W. Va. Bd. of Med.*, 212 W. Va. 149, 158, 569 S.E.2d 225, 234 (2002) (holding that an agency decision must be “upheld, if at all, on the same basis articulated in the order by the agency itself”). The BMS theory against “passing on the cost of negligence claims” (e.g. Br. at 3) is an objection to liability insurance itself. Insurance premiums are paid so that the insurer pays the negligence claims, and the rates reflect the actual experience and risk of the particular company insured. Whether those negligence claims are paid entirely indirectly, through insurance premiums, or through a mixture of direct and indirect payments (direct claim payments and liability premiums) is a matter of form, not substance. The relevant question is: What is the least expensive method of providing the protection? In both cases, the money ultimately goes to settle or pay negligence claims. From the public policy perspective, the goal is to minimize cost to the Medicaid program. In this case, it was undisputed that HCR procured the lowest-cost solution actually available to it.

B. The Circuit Court Erred in Failing to Grant HCR’s Motion for Discovery and Failing to Review the Entire Administrative Record and Supplemental Evidence.

1. HCR was entitled to requested discovery in its petition for certiorari.

HCR was entitled to the requested discovery in its petition for certiorari to the circuit court. The Bureau dedicates several pages of its brief to HCR’s request for discovery at the circuit court and yet fails to include any legal basis for its opposition to HCR’s request other than its citation to *Bills v. Hardy*, 228 W. Va. 341, 719 S.E.2d 811 (2001), which the Bureau concedes authorizes the circuit court to take evidence.

The Bureau's suggestion that HCR's request for discovery was untimely is specious. The Bureau points to no deadline for such a request, and there is none. The Bureau concedes on page 10 of its brief that the administrative proceedings provided no mechanism for conducting discovery. The circuit court identified two central issues that it indicated could affect the outcome of this matter for the first time during the hearing on April 9, 2015: (1) whether the Bureau has been approving inclusion of settlement and other liability costs beyond liability insurance premiums in setting rates for other providers; and (2) whether the Bureau was on notice that other providers included settlement and other costs in their cost report submissions to BMS. Accordingly, HCR promptly filed a motion for discovery in the circuit court following the hearing. HCR's request for discovery was timely under the circumstances.

BMS misleads the Court as to the ability of HCR to obtain and produce evidence with regard to actions of BMS. In the administrative process, HCR had no access to discovery procedures. It could not serve discovery requests on BMS nor could it obtain and serve subpoenas on third parties. HCR was aware from its expert that it is common for providers in West Virginia to report settlement and other direct liability costs as part of their allowable costs. At the hearing, HCR's expert, whose firm works for most of the nursing homes in the state, testified that other West Virginia nursing facilities "routinely" report direct liability costs (such as settlement payments) as part of the taxes and insurance cost center. A.R. at 289-90. HCR was taken by surprise by the Bureau's denial of this fact.

BMS further misstates the record in claiming that only HCR had access to the information regarding prior BMS practices and BMS decisions to approve costs that included direct liability claim costs. Although the BMS brief repeats the claim that it had never knowingly allowed inclusion of direct liability costs, after the hearing HCR obtained emails involving

Golden Living, directly contradicting that claim. The absence of discovery procedures in the administrative process precluded HCR from seeking the information from either the Bureau or third parties. Only happenstance enabled HCR to obtain access to the emails that were from and to the Bureau's witness (Jeanne Snow) who claimed that BMS had not previously known of and approved such costs. Although the emails were to and from the Bureau's own witness, BMS did not challenge the authenticity of the documents, but instead demanded exclusion because it could not cross examine the other party to the exchanges – the Golden Living employee. But HCR not only lacked access to the emails at the time of the hearing, it could not have subpoenaed the Golden Living employee, because no discovery procedures are available in the administrative process.

The Bureau's brief also conceals the steps the Bureau took at the hearing to silence HCR's expert. After being advised by the expert, Mr. Ellis, of his ethical concerns about disclosing the names of clients reporting direct liability costs, the Hearing Examiner asked the Bureau's attorney about "her position on sealing the transcript." A.R. at 317. The Bureau's attorney declined to agree, stating: "[w]e would actually use the information to go after and look at those facilities." *Id.* That threat effectively silenced HCR's expert. Strangely, the Bureau's brief contends that HCR made a choice not to have the expert disclose the information, as if an independent expert was under the control of HCR. HCR had no such control over an independent CPA and his view of his ethical duties. HCR's counsel did no more than recognize the effect of the Bureau's threat, and note that he could not advise Mr. Ellis that his ethical obligations were not violated. A.R. at 326.

The Bureau's response makes it clear that the real reason it disallowed HCR's first dollar losses and liability costs up to its deductibles was simply an instinctive view that they were too

high, rather than any rule of law that mandated exclusion of these otherwise allowable insurance costs. As discussed above, HCR explained in detail its insurance program, the layers of coverage, and its ongoing efforts to ensure that it had left undetected no superior alternative to its high deductibles. A.R. at 186-89. HCR explained on cross-examination that the insurance brokers who advised it recommended the program of insurance, and HCR agreed that it was the most economical program available. A.R. at 202. The Bureau has never addressed HCR's evidence on the reasonableness of its insurance program and deductibles, and the Bureau has never previously argued that the rates were excessive in light of the actual options available to HCR. Instead, the Bureau has simply complained that its CAP methodology resulted in a number that is too high. This issue should be waived. *See State v. LaRock*, 196 W. Va. 294, 470 S.E.2d 613, 635 (1996) (noting "[o]ne of the most familiar procedural rubrics in the administration of justice is the rule that the failure of a litigant to assert a right in the trial court likely will result in the imposition of a procedural bar to an appeal of that issue") (citations omitted). Nonetheless, if the Court determines that remand is appropriate for HCR to engage in discovery and does not apply the waiver doctrine to bar the Bureau's new argument, limited discovery on this issue may be appropriate as well.

Because there was no opportunity for discovery below, and because at the hearing the Bureau actively prevented exploration of the issues identified by the circuit court, due process and fundamental fairness required that the record be reopened by the circuit court and discovery allowed on those points. The requested discovery would have enabled HCR to have a full and fair opportunity to discover and present the relevant evidence to support its position with regard to the issues identified by the circuit court during the hearing. The circuit court's failure to allow such discovery is prejudicial error that requires a remand for further proceedings.

2. The circuit court should have reviewed the entire administrative record, including evidence stricken and proffers made, and supplementations.

Finally, the circuit court should have reviewed the entire administrative record, including evidence stricken and proffers made, and supplementations made in the circuit court. The Bureau concedes on page 21 of its brief that Mr. Ellis testified that most West Virginia nursing home facilities routinely reported direct liability payments below any deductible as part of their cost reports although it erroneously states that this was prior to January 1, 2012, instead of 2013, as Mr. Ellis actually testified. A.R. at 289-90. Moreover, the Bureau does not dispute that HCR proffered the affidavit of Ms. Martin in rebuttal to the unexpected testimony of Ms. Snow that she was not aware that other providers submitted such costs. The hearing examiner erred in striking Mr. Ellis's testimony as well as Ms. Martin's affidavit, and the circuit court should have reviewed this evidence.

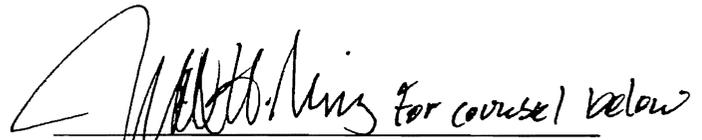
The hearing examiner's error was exacerbated because the Bureau transmitted only the hearing transcript to the circuit court although HCR designated the entire administrative record for review in connection with the petition for certiorari. A.R. at 40, 43. Because of the Bureau's neglect, HCR was required to include Ms. Martin's affidavit in its supplemental statement of evidence in response to the circuit court's directive that HCR provide any specific references as to whether the Bureau was on notice that other providers included settlement and other costs in their cost reports. A.R. at 802-38. The circuit court should have considered Mr. Ellis's testimony and Ms. Martin's affidavit because they are relevant to the issues identified by the circuit court and wrongly stricken or excluded by the hearing examiner. In conducting its *de novo* review, the circuit court should have considered the entire administrative record, including those parts that were improperly stricken or excluded by the hearing examiner and those parts

designated by HCR but omitted by the Bureau. Because of the Bureau's omission, HCR was forced to submit its supplemental statement of evidence to provide the circuit court with another opportunity to review relevant evidence. The Bureau's suggestion, on pages 11 and 24 of its brief, that HCR's counsel responded inaccurately to questions from the circuit court or misrepresented the record is meritless and completely ignores the Bureau's own omission. The circuit court's failure to consider the whole record constitutes prejudicial error.

III. CONCLUSION

For all of the foregoing reasons, this Court should reverse the circuit court's final order and remand this action for allowance of the losses relating to deductibles at issue. In the alternative, the Court should vacate the circuit court's judgment and remand this action for further proceedings.

Respectfully submitted this 19th day of November 2015.



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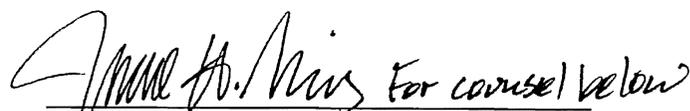
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CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of November 2015, I caused the foregoing "Reply Brief of Petitioners" to be served on counsel of record via U.S. Mail in a postage-paid envelope addressed as follows:

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